STATE OF MONTANA
Department of Public Health and Human Services
Human & Community Services Division

Best Beginnings
Montana DPHHS/
Child Care & Development Fund

2008-2009
MERIT PAY
REQUEST TO CHANGE PLAN OF STUDY

NAME_____PS NUMBER_____

DATE OF BIRTH_____SSN_____

MAILING ADDRESS_____CITY_____ZIP_____

WORK PHONE_____HOME PHONE_____

☐ ***Check here if this is a new address***

Original Plan of Study training/course to be changed:	**Number of Hours**
Requested Change/Substitution course:	**Number of Hours**

Please use another sheet of paper if more space is needed.
I certify all information given is true and correct.
Applicant Signature:_____ **Date:**_____

Merit Pay participants must be actively working a minimum of 15 hours in a licensed/registered child care facility when payment is requested. Merit Pay participants much attach verification of training completed and a copy of their MT Early Care & Education Practitioner Registry before payment will be released. Non-college credit training can be verified and a copy printed at www.montana.edu/ecp/personnel using your PS number.

FOR ECSB OFFICE USE ONLY APPROVED BY: DATE: